

**Tripler Army Medical Center
and
Schofield Barracks**

Department of Obstetrics

OB Registration Packet



**Please complete prior to attending your
initial OB appointment.**

**Tripler Army Medical Center Central Appointment Line:
433-2778 ext. 4-1-1**

Schofield Barracks OB Appointment Line: 433-8175

OBSTETRIC CARE
at
Tripler Army Medical Center
and
Schofield Barracks
OB Clinics

Congratulations from the staff of Tripler Army Medical Center & Schofield Barracks OB clinics. We would like to share the care options you have here. Please consider which option would best meet your needs and let us know which option you prefer:

You have options when choosing your OB care:

1. Tripler Army Medical Center: Uncomplicated and Complicated (high risk) OB care for the duration of your pregnancy.
2. Schofield Barracks OB Clinic: You can receive your OB care up to 40 weeks as long as there are no complications. Every attempt will be made to provide continuity of care; however, OB Staff and Residents will be rotating through the clinic.
3. Certified Midwife Program (Tripler only): Allows you to be seen by the Nurse Midwives during your pregnancy and then have a midwife on call present for the birth of your baby. You must meet specific program criteria to be enrolled. If you are interested, request an appointment with one of the midwives and discuss your interest with them. These appointments are limited to women who have a low risk of needing any intervention during delivery.

Your baby will not necessarily be delivered by the Provider that you see in the clinic as all Providers rotate through Labor & Delivery.

CONSENT FOR SCREENING
(non-active duty)

I have read the information on the reverse side and understand the contents.

Date _____ Active Duty : _____
(patient signature)

Non-active : agree to testing _____ or _____
duty testing (patient signature) (sponsor/legal guardian signature)
(circle which)

Physician's signature _____

Physician's printed name _____

Date _____ Active Duty : _____
(patient signature)

Non-active : agree to testing _____ or _____
duty testing (patient signature) (sponsor/legal guardian signature)
(circle which)

Physician's signature _____

Physician's printed name _____

Date _____ Active Duty : _____
(patient signature)

Non-active : agree to testing _____ or _____
duty testing (patient signature) (sponsor/legal guardian signature)
(circle which)

(Patient Identification)

Physician's signature _____

Physician's printed name _____

Approved for filing in the medical records by
the Medical Records Review Committee on 2 Dec 87.

INFORMATION SHEET & CONSENT FORM

ROUTINE ADJUNCT PATIENT SCREENING PROGRAM FOR HIV INFECTION

1. The Army has initiated a program for screening patients for the presence of HIV (Human Immunodeficiency Virus) infection. HIV is the virus that causes AIDS. Routine testing assists physicians in being fully aware of a patient's health status, helps prevent the spread of infection, and provides important information on the distribution of disease.
2. This HIV screening program is mandatory for active duty military members. AD will have their blood drawn and tested unless there is military documentation of an HIV test result within the previous 12 months.
3. This HIV screening program is voluntary for non-active duty beneficiaries of military medical care. As a civilian you have the absolute right to refuse to have this blood test performed. No patient who declines screening under this program will be denied appropriate care.
4. The screening test for HIV antibody requires that a blood sample be obtained using a needle and syringe.
5. The blood sample obtained is tested for the presence of HIV antibodies. The presence of HIV antibodies means one is *infected* with the AIDS virus. It *does not* mean that one has the *disease* AIDS.
6. A **NEGATIVE TEST** means that no antibodies to the AIDS virus have been found in your blood at this time. There are three possible explanations for this:
 - * You have not been exposed to the virus.
 - * You have been exposed to the virus, but have not been infected and therefore you have not produced antibodies.
 - * You have recently been infected by the virus but your body has not made enough antibodies to be detected yet.
7. A **POSITIVE TEST** means that:
 - * Your blood has been tested and retested and the tests show that antibodies to HIV have been found in your blood.
 - * You have been exposed to the HIV and your body has made antibodies.
 - * You can pass the virus on to others.
8. A person identified as HIV antibody positive could infect others through sexual activity, pregnancy, or contact from body fluids (including blood). This person could also have an adverse reaction to certain drugs, immunizations, and prenatal, dental, medical and surgical treatments.
9. If your test is positive, you will be notified by your doctor and receive additional medical evaluation and counseling.
10. The results of a confirming, positive screening test will be placed in your medical record and appropriate persons involved in health care will have access to that information. The HIV test results are considered confidential and the test results in the medical record shall not be released without the patient's written permission, except to the individuals and organizations who are authorized access under state and federal laws or regulations.
11. You will be provided with an educational handout that provides basic information regarding AIDS and are encouraged to ask questions of your doctor.

(see reverse)

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-86; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

TAMC Prenatal Genetic Screen*

OTSG APPROVED (Date)

(YYYYMMDD)

4 Nov 87

Date _____

1. Will you be 35 years or older when the baby is due? Yes _____ No _____
2. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?
 Down syndrome (mongolism) Yes _____ No _____
 Other chromosomal abnormality Yes _____ No _____
 Neural tube defect, i.e., spina bifida (meningomyelocele or open spine), anencephaly Yes _____ No _____
 Hemophilia Yes _____ No _____
 Muscular dystrophy Yes _____ No _____
 Cystic fibrosis Yes _____ No _____
 If yes, indicate the relationship of the affected person to you or to the baby's father: _____
3. Do you or the baby's father have a birth defect? Yes _____ No _____
 If yes, who has the defect and what is it? _____
4. In any previous marriages, have you or the baby's father had a child, born dead or alive, with a birth defect not listed in question 2 above? Yes _____ No _____
 If yes, what was the defect and who had it? _____
5. Do you or the baby's father have any close relatives with mental retardation? Yes _____ No _____
 If yes, indicate the relationship of the affected person to you or to the baby's father: _____
 Indicate the cause, if known: _____
6. Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal abnormality not listed above? Yes _____ No _____
 If yes, indicate the condition and the relationship of the affected person to you or to the baby's father: _____
7. In any previous marriages, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses? Yes _____ No _____
 Have either of you had a chromosomal study? Yes _____ No _____
 If yes, indicate who and the results: _____
8. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease? Yes _____ No _____
 If yes, indicate who and the results: _____
9. If you or the baby's father are black, have either of you been screened for sickle cell trait? Yes _____ No _____
 If yes, indicate who and the results: _____
10. If you or the baby's father are Italian, Greek, or Mediterranean background, have either of you been tested for β -thalassemia? Yes _____ No _____
 If yes, indicate who the results: _____
11. If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for α -thalassemia? Yes _____ No _____
 If yes, indicate who and the results: _____
12. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? (include nonprescription drugs.) Yes _____ No _____
 If yes, give name of medication and time taken during pregnancy: _____

*Any patient replying "YES" to questions should be offered appropriate counseling. If the patient declines further counseling or testing, this should be noted in the chart.

Patient request Genetic Counseling Yes _____ No _____

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE (YYYYMMDD)

Department of Obstetrics-Gynecology

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

- | | |
|--|--|
| <input type="checkbox"/> HISTORY/PHYSICAL | <input type="checkbox"/> FLOW CHART |
| <input type="checkbox"/> OTHER EXAMINATION OR EVALUATION | <input type="checkbox"/> OTHER (Specify) |
| <input type="checkbox"/> DIAGNOSTIC STUDIES | |
| <input type="checkbox"/> TREATMENT | |

COMMUNITY HEALTH NURSING - CASE REFERRAL

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General

TO: (Name and location)

New Parent Support Program
Honolulu, Hawaii

FROM: (Name and location)

Tripler Army Medical Center
Schofield Barracks Health Clinic

1. NAME OF PATIENT (Last, First, Middle Initial)

2. ADDRESS OF PATIENT (Give specific directions)

3. DATE OF BIRTH

4. HOME PHONE

5. NAME OF SPONSOR (Last, First, Middle Initial)

6. GRADE AND SSN

7. OFFICE PHONE

8. ORGANIZATION

9. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of the medical information relevant to this referral to the New Parent Support Program for planning of prenatal health services.

Signature of Patient (or person authorized to consent for patient)

Date

10. REASON FOR REFERRAL; OTHER SIGNIFICANT DATA

Branch of Service: _____ Age: _____ Marital Status: _____ No. of Pregnancies _____ No. of Children: _____

1. How are feeling about being pregnant? _____ Partner _____

2. What concerns or worries do you have? _____

3. What experiences do you have caring for a newborn baby? _____

4. Do you have parenting concerns now? No [] Yes [] _____

5. Who do you have that you can depend on for help? _____

6. What do you do when you feel stressed or frazzled? _____

7. In a few words, what was your childhood like? _____

8. Have you ever been emotionally abused? No [] Yes [] When _____ By whom _____

9. Have you ever been hit, slapped, kicked, pushed, or otherwise physically hurt in the past or during this pregnancy?
No [] Yes [] if yes, when _____ By whom _____10. Have you ever experienced forced sexual activities? No [] Yes [] if yes, when _____
by whom _____11. If you were emotionally, physically or sexually abused, how does it affect you now? _____
Are you safe now? No [] Yes []

12. Have you had counseling? Yes [] No [] Do you want it now? Yes [] No [] _____

13. Do you feel safe in your home/personal relationship? Yes [] No [] _____

14. Other comments: _____

11. SIGNATURE OF INITIATOR

12. DATE

13. LOCATION OF RECORDS (Check applicable box(es))

MEDICAL RECORDS ☐ ARE ☐ ARE NOT IN FILES OF THIS INSTALLATION.FAMILY RECORDS ☐ ARE ☐ ARE NOT IN FILES OF THIS INSTALLATION.

This form in and of itself DOES NOT constitute a contract with the Army for payment of services to be rendered.

14. REPORT OF FINDINGS AND RECOMMENDATIONS

(For Clinic RN): LMP: _____ Gestation in Weeks: _____ EDC: _____

15. SIGNATURE OF INDIVIDUAL COMPLETING ITEM 14.

16. DATE

DATA REQUIRED BY THE PRIVACY ACT OF 1974

1. AUTHORITY: 5 US Code 301; 10 US Code 1071; 42 US Code; 44 US Code 3101.
2. PRINCIPAL PURPOSE(S): Provides a means for medical and allied medical personnel to refer individuals and families for Army community health nursing services.
3. ROUTINE USES: a. To refer patients or family units to other military and civilian health and welfare agencies or to Army community health nurses at other military installations.
 b. A case referral which contains medical information requires written consent of the patient or legal representative prior to release to a civilian agency.
 c. A doctor's signature is required when medication and/or treatments are ordered.
 d. To provide continuity of care, minimize duplication of effort and furnish accurate information to other health care providers.
 e. When case is completed or inactive, one copy of record is returned to the initiator (item 2, above) and duplicate copies of record are destroyed when no longer needed.
4. MANDATORY OR VOLUNTARY DISCLOSURE: Voluntary however failure to provide information may prevent continuity of care, cause duplication of effort and prevent accuracy of information to other health care providers.

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR

SSN OF MEMBER OR SPONSOR

DATE

OB Registration

Please fill this form out completely before your appointment with the nurse.

Your Last Name <input style="width: 90%;" type="text"/>	First Name <input style="width: 90%;" type="text"/>	THE SPONSOR'S SSN <input style="width: 95%;" type="text"/>
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Filipino <input type="checkbox"/> Korean <input type="checkbox"/> Japanese <input type="checkbox"/> Samoan <input checked="" type="checkbox"/> Chinese <input type="checkbox"/> Mexican <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> _____	Primary Language Your Date of Birth <input type="checkbox"/> English <input type="checkbox"/> _____ Religious Preference <input type="checkbox"/> _____ _____/_____/_____ MONTH/DAY/YEAR Check one: (you are) <input type="checkbox"/> Dependent <input type="checkbox"/> Active Duty (O-1, E-1, etc)

Sponsor's:		
Branch of Service: _____	Base/Post Stationed at: _____	Military Unit: _____

Husband / Sponsor's:			
Last Name <input style="width: 90%;" type="text"/>	First Name <input style="width: 90%;" type="text"/>	Date of Birth ____/____/_____ MONTH/DAY/YEAR	Check one: <input type="checkbox"/> Dependent <input type="checkbox"/> Active Duty (O-1, E-1, etc)
Father of Baby is <input type="checkbox"/> Aware of my pregnancy <input type="checkbox"/> Supportive of pregnancy		Father's Ethnicity: _____	

Address:	
<input style="width: 95%;" type="text"/> <small>Street</small>	
<input style="width: 95%;" type="text"/> <small>City, State, Zip</small>	
<input style="width: 90%;" type="text"/> <small>Home Phone</small>	<input style="width: 90%;" type="text"/> <small>Work Phone</small>

Please rank the following according to your daily use:						
Smoking: (per day)	<input type="checkbox"/> Never	<input type="checkbox"/> Recently Quit	<input type="checkbox"/> Light <small>< one pack</small>	<input type="checkbox"/> Moderate <small>1-1.5 pack</small>	<input type="checkbox"/> Heavy <small>1.5-2 packs</small>	<input type="checkbox"/> Very Heavy <small>>2 packs</small>
Alcoholic Beverages:	<input type="checkbox"/> Never	<input type="checkbox"/> Recently Quit	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy	<input type="checkbox"/> Very Heavy
Caffeinated Beverages:	<input type="checkbox"/> Never	<input type="checkbox"/> Recently Quit	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy	<input type="checkbox"/> Very Heavy
I am taking:	<input type="checkbox"/> Prenatal Vitamins		<input type="checkbox"/> Iron Supplements		<input type="checkbox"/> Folic Acid	
Please list any other medications, vitamins or herbal supplements that you take on a regular basis: _____ _____						

Please let us know if you have any problems with the following parts of your body by checking the block and giving a short description, to include dates.

- ☐ GENERAL _____
- ☐ HEAD/MIGRAINES _____
- ☐ EYES/GLASSES/CONTACTS _____
- ☐ EAR _____
- ☐ NOSE _____
- ☐ NECK _____
- ☐ THROAT _____
- ☐ LUNGS _____
- ☐ HEART _____
- ☐ STOMACH/INTESTINES/BOWEL MOVEMENTS _____
- ☐ URINARY/KIDNEYS/URINARY TRACT INFECTIONS _____
- ☐ GYN/UTERUS/OVARIES/CERVIX/ABNORMAL PAP SMEARS _____
- ☐ BLOOD/ANEMIA/SICKLE CELL/HEPATITIS _____
- ☐ LYMPH _____
- ☐ MUSCLES/BACK _____
- ☐ NEURO/PSYCH/ANXIETY/DEPRESSION/EATING DISORDERS _____
- ☐ OTHER _____

Please check the box if you have **ever** been treated for any of the following: (Include dates)

- ☐ HYPERTENSION/PRE-ECLAMPSIA _____
- ☐ HERPES _____
- ☐ SEXUALLY TRANSMITTED DISEASES _____
- ☐ BLOOD TRANSFUSION _____
- ☐ MORE THAN TWO URINARY TRACT INFECTIONS IN ONE YEAR _____
- ☐ SEIZURE _____
- ☐ THYROID PROBLEMS _____
- ☐ ASTHMA _____
- ☐ DIABETES _____
- ☐ CARDIAC PROBLEMS _____
- ☐ PULMONARY PROBLEMS _____

Do you own any cats ☐ YES ☐ NO

Please check the box if you **(the mother)** has a family history of any of the following.

If you do, state the relationship to you. Remember, we only need to know if it is on *your* side of the family.

- ☐ TWINS _____
- ☐ BIRTH DEFECTS _____
- ☐ DIABETES _____
- ☐ CANCER _____
- ☐ HEART DISEASE _____
- ☐ HIGH BLOOD PRESSURE _____

Are you allergic to any food or medication? ☐ YES ☐ NO

If yes, please write what you are allergic to and what happens to you.

I have had the following childhood illnesses:

(Please check the appropriate box.)

☐ NONE ☐ CHICKEN POX ☐ MEASLES ☐ MUMPS ☐ RHEUMATIC FEVER

Please list any past operations/surgeries that you have had.

Include the month and year they occurred.

First day of your last menstrual period: _____ Height: _____ Usual Weight: _____

Including this pregnancy, how many times have you been pregnant? _____

How many children do you have now? _____

How old were you when you had your first period? _____

Are your periods ☐ REGULAR ☐ IRREGULAR

How often did your periods occur? Every _____ days.

Rate the amount of pain that you experience with your menstrual cycle.

☐ NONE ☐ MILD ☐ MILD-MODERATE ☐ MODERATE ☐ SEVERE ☐ IRREGULAR

How many days do you bleed for during your menstrual period? _____

Past Pregnancies: Please fill out the chart below. Include any miscarriages or elective terminations that you have had.

Date	How many weeks you were at delivery	Hours of labor	Type of Anesthesia used	Vaginal, C/S, forceps, vacuum	Hospital and State	Sex of Baby	Weight	Any Complications/ Hospitalizations During Pregnancy/Medications

Have you ever had a positive Tuberculosis or TB Tine Test? ☐ YES ☐ NO If yes, when: _____

Were you born outside of the United States? ☐ YES ☐ NO If yes, where: _____

Have you ever lived outside of the United States for more than 30 days? ☐ YES ☐ NO

Have you ever had active TB or lived with someone with active TB? ☐ YES ☐ NO

Have you ever taken any medications for TB? ☐ YES ☐ NO If yes, when: _____

What medication(s): _____ How long: _____

Is this a planned pregnancy? ☐ YES ☐ NO

Are you experiencing any: ☐ NAUSEA ☐ VOMITING ☐ CRAMPING ☐ BLEEDING

How will you feed your baby? ☐ BREAST FEED ☐ BOTTLE FEED ☐ UNDECIDED

How would you describe your appetite? _____

Are you on any kind of special diet? ☐ NO ☐ YES. What kind? _____

Do you have any food cravings? ☐ NO ☐ YES. They are _____

Do you avoid any foods? ☐ NO ☐ YES. They are _____

How many times do you eat in one day? _____

What topic(s) do you want/need education on?

<input type="checkbox"/> YES <input type="checkbox"/> NO	Prenatal Care	<input type="checkbox"/> YES <input type="checkbox"/> NO	Home Visiting Nurse
<input type="checkbox"/> YES <input type="checkbox"/> NO	Childbirth Preparation Classes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Couples Counseling
<input type="checkbox"/> YES <input type="checkbox"/> NO	Breastfeeding	<input type="checkbox"/> YES <input type="checkbox"/> NO	Individual Counseling
<input type="checkbox"/> YES <input type="checkbox"/> NO	Infant Care	<input type="checkbox"/> YES <input type="checkbox"/> NO	Stress/Anger Management
<input type="checkbox"/> YES <input type="checkbox"/> NO	Labor and Delivery Tour	<input type="checkbox"/> YES <input type="checkbox"/> NO	Financial Planning
<input type="checkbox"/> YES <input type="checkbox"/> NO	WIC	<input type="checkbox"/> YES <input type="checkbox"/> NO	Single Parents Group
<input type="checkbox"/> YES <input type="checkbox"/> NO	Sibling Classes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Domestic Violence Treatment

What is the best method of learning for you? ☐ Reading ☐ Videos ☐ Computer ☐ Demonstration

What is the highest school grade that you have completed? _____

Do you have any recurring pain management concerns? ☐ Yes ☐ No

Do you have any financial hardships that prevent you from getting medical care? ☐ Yes ☐ No

Do you have any cultural, language or religious preferences? ☐ Yes ☐ No

If yes: _____

During the past month, have you often been bothered by feeling down, depressed or hopeless? ☐ Yes ☐ No

During the past month, have you often been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No